BD-0021-0704

State of New Jersey — Department of the Treasury
Division of Pensions and Benefits • PO Box 297 • Trenton, NJ 08625-0297 • (609) 292-7524

MEDICAL EXAMINATION BY PERSONAL OR TREATING PHYSICIAN

This form must be filed in support of an Application for Disability Retirement and is restricted to the confidential use of the retirement system.

PART ONE — *APPLICANT* (COMPLETE PART ONE BEFORE PRESENTING THIS FORM TO THE PHYSICIAN.)

Name _____ Date of Birth _____
Last, First, Middle Initial *Month, Day, Year*

Social Security Number _____ Job Title _____

PART TWO — *PHYSICIAN* (PLEASE TYPE OR PRINT CLEARLY.)

Please complete this form in its entirety. You may include copies of office notes to provide additional documentation but **each question must be answered on this form.** An incomplete form will be returned to the member and will delay processing of the application.

1. History of the illness or injury causing the disability and any other pertinent past or present history:

2. Positive physical findings:

3. Significant laboratory, cardiographic, x-ray or other diagnostic data: (If available, please attach copies of narrative reports only. No films please.)

4. Diagnosis:

5. Is the applicant totally and permanently disabled and no longer able to perform his or her job duties:

☐ NO ☐ YES

If Yes, explain in what way the applicant's symptoms or physical findings prevent him or her from working:

6. a) Is the applicant's disability likely to be stable or progressive? ☐ Stable ☐ Progressive

b) If progressive, is death imminent? ☐ NO ☐ YES

c) Is there a possibility that the applicant might improve to a degree to perform the applicant's duties?

☐ NO ☐ YES

7. Is the applicant permanently and totally disabled as a direct result of an accident that occurred during the performance of the applicant's regular assigned duties?

☐ NO ☐ YES

If yes, explain the causal relationship:

(PLEASE TYPE OR PRINT CLEARLY.)

Physician's Name:_____ Degree: _____

Address:_____

_____ Phone: (____) _____

Specialty: _____ NJ License Number: _____

_____ _____

Signature of Physician *Date*